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All We are Saying is Give the Endogenous Depression Concept a Chance: Its Utility is Indispensable for Treatment

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Abstract

"Utsubyo" in Japanese is similar to major depressive disorder (MDD) as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). "Utsubyo (DSM-5)/major depressive disorder" was agreed upon in 2014; however, utsubyo was diagnosed in Japan before the DSM-5. It was called endogenous depression.

Endogenous depression is a disease whereas MDD is a syndrome. A disease presupposes a physical cause underlying the symptoms. The basis of MDD does not have to be physical, it can be a depressive or sad event (depressive reaction) or a conflict repressed in the unconscious (depressive neurosis).

Depression and sadness in endogenous depression are manifested in the area where the mind and body intersect. Vital depression, vital sadness, vital inhibition, inability to mourn, and primary suicidal ideation are different in quality from the depression experienced in daily life and are unresponsive to empathic or sympathetic support.

The DSM term "loss of pleasure" refers to the unresponsiveness and nonreactivity of mood in endogenous depression. It is also called anhedonia. In particular, loss of consummatory pleasure has high sensitivity and specificity for endogenous depression and is an important indicator of the efficacy of antidepressants.

Diagnosis of endogenous depression is for the purpose of treatment. Diagnosis, education, consent, and information of the procedure lead to a good outcome.

Electroconvulsive therapy or tricyclic antidepressants and a psychotherapeutic attitude based on an understanding of the psychopathology of the disease are essential in treatment. Kasahara summarized this in little psychotherapy, and Okuma added that encouragement of the patient is contraindicated. In addition to the therapeutic significance of the diagnosis of endogenous depression itself, physical treatment and psychotherapeutic guidelines specific to the diagnosis were given. This is the utility of the concept of endogenous depression.

Keywords: depression, mild depression, endogenous depression, psychotherapy, encouragement

Introduction

When we tire of classifying clinical depression based on contemporary guidelines, we would like to give the concept of endogenous depression a chance to be re-evaluated.

In the "Guidelines for the Treatment of Depression, Second Edition," published in 2016 and supervised by the Japanese Society of Mood Disorders, "Utsubyo" is synonymous with major depressive disorder (MDD) as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) of the American Psychiatric Association. It can be translated as "Utsubyo (DSM-5)/Dai–utsubyo" or "Utsubyo (DSM-5)/Dai–utsubyo–sei–shogai" *1 18). It is a concept imported and translated from the United States.

On the other hand, even before the DSM defined MDD*2, Japan had its own unique diagnosis of depression*3, which is endogenous depression 25)26). The meaning of the term "endogenous" includes the following: "It has a significant genetic and constitutional component, and develops spontaneously without any psychological trigger. The course of the disease after onset is not influenced by external factors".

Furthermore, endogenous depression has different meanings in mild and severe cases.

Mild: Can be treated on an outpatient basis. Patients are aware of the disease. The main symptoms are vital depression and non-reactivity of mood.

Severe: Requires admission to a psychiatric hospital. Patients do not have consciousness of illness. The main symptoms are impatience, agitation, catatonia, delusion of guilt, delusion of poverty, hypochondriacal delusion, etc.

Originally, the term "endogenous depression" was used to describe a mild form of depression 5)22)36)37). It is called "endogenous" depression to distinguish it from "psychogenic" depression such as neurotic depression, depressive personality disorder, and depression in adjustment disorder. However, in accordance with the DSM-5 "Characteristics of Melancholia" 4), the modern usage of the term "endogenous" depression has come to be used predominantly in the sense of "severe" depression.

In this paper, we discuss mild endogenous depression. This was called "prototype depression" 7), "core group of depression" 33)34), and "real depression" 17) until around 2010. At that time, pathologies that should be called "derivative types of depression," "marginal groups of depression," or "fake depression" were in the spotlight. Soon, the prototypes, core group, and genuine form of depression were swallowed up and buried by the torrent of derivative types, marginal groups, and fake depression 26). They just lent their eaves but took all of the main house. The end result was MDD, or "Depression (DSM-5)/Major Depressive Disorder".

As of 2021, endogenous depression appears to have been upgraded to MDD and is no longer supported, much like Windows XP*4. Those of us who have been engaged in clinical psychiatry for more than 20 years fondly recall that comfortable operating environment. However, those who continue to use it by maintaining it today are considered to be whims. Those who began clinical psychiatry during the past decade are not familiar with the concept itself, even if they are familiar with the name. They have no experience using them. However, there is no need to worry. They can still become a specialist.

Understandably, not all of the clinical experience with the concept of endogenous depression has been abandoned. A small amount of it has been transferred to MDD 8)18). However, endogenous depression and MDD differ in both diagnostic categories and the conditions they point to. Therefore, if we apply the predictions of course and prognosis and treatment policies for endogenous depression to MDD other than endogenous depression, i.e., to its former derivatives, marginal groups, and fake depression, a mismatch will occur. This causes discomfort among clinical workers and distrust among patients and other concerned people. One such question is: "Has the adage 'Do not encourage the depressed' lost its validity?" Since "depression" in this adage refers to endogenous depression, applying this adage to MDD in general would cause a discrepancy. This is only natural.

Therefore, for this paper, the author will make waves and call attention to the difference between endogenous depression and MDD. Then, the usefulness of the endogenous depression concept in the modern age will be presented.

I. Differences between endogenous depression and MDD

Endogenous depression is a disease 27). A disease presupposes a physical cause that underlies the symptoms and course of the disease. The nature of the symptoms and course of endogenous depression suggests that there must be a physical cause underlying the disease 31). However, it is not currently known what the physical cause is. Those with a known physical cause have symptomatic/organic depression, such as depression in patients taking reserpine or with hypothyroidism.

On the other hand, MDD is a syndrome 4)28). A syndrome is not premised on a physical cause. A syndrome is a collection of symptoms itself*5. The basis can be anything. MDD is that with or without a physical cause.

The relationship between endogenous depression and MDD can be compared with the relationship between pneumonia and a cough 23). When a person has pneumonia, he or she coughs. When pneumonia is cured, the coughing stops. However, stopping the cough does not cure pneumonia. Similarly, a person with endogenous depression will complain of MDD symptoms. They make negative comments and lose willpower. When the endogenous depression is in remission, i.e., when the underlying physical causes are resolved, the symptoms of MDD disappear. However, it is futile to try to encourage the patient to stop the negative comments and regain his/her motivation in MDD. The physical causes underlying endogenous depression cannot be cured. It is like saying: "Your cough causes pneumonia, so stop coughing".

Coughing does not necessarily mean pneumonia. It could be asthma or a cookie stuck in your throat. Similarly, the basis of MDD does not have to be a physical cause such as endogenous depression. It can be an event that causes depression and sadness, or it can be a mental conflict that is repressed in the realm of the unconscious. MDD is the final common pathway arising from all of these events 1)38). In the era of endogenous depression, MDD arising from an event was called a depressive reaction, and MDD arising from a mental conflict was called a depressive neurosis. Specifically, they are as follows 23)26):

D, a mechanical cat, was sent from the 22nd century future to the present day to help N, a lazy elementary school

student, grow up*6. D helped N using the tools of the future and built a trusting relationship with him.

Episode 1: However, D was forced to return to the future in the course of the project, and had to part ways with N. Depressive reactions (sadness) were depicted in the farewell episode.

Episode 2: After many twists and turns, the story is not censored and D is allowed to return to N. They rejoice with each other. Their relationship seems to last forever. However, despite D's efforts, N does not seem to have any ambition. Instead, he becomes increasingly dependent on D. D continues to be troubled by the conflict that his presence in the relationship is stifling N's growth. This conflict may be related to the absence of parents in D's upbringing. This is depressive neurosis.

Episode 3: Nevertheless, thanks to D's efforts, the time eventually comes when N becomes mentally independent. There is a chance that he will marry S, the girl of his dreams, in the future. D, however, is only de-motivated by the fact that he has achieved his goal, and for some reason he is not truly happy about it. He has more trouble than ever getting his tools out of his pockets, and he cannot think of the right tool for the right situation. D cannot hide his bewilderment. He eats his favorite food, dorayaki, but it does not taste good at all. He is not surprised when his natural enemy, the rat, appears. This is endogenous depression, and it will not be long before D disappears. In fact, when N goes to see his future self and his family, D is not there.

Even if episodes 1 to 3 are all MDD syndromes, they should not be considered as three recurrences. The basis for each episode is different: 1 is an event, 2 is an emotional conflict, and 3 is a physical cause. A treatment plan must be selected for each of these bases. Sticking a diagnosis of "depression" on everything and administering antidepressants is like injecting an intravenous steroidal drug when the patient is coughing with a cookie stuck in his/her throat, or trying to suck out a cookie that is not there by forcing an electric vacuum cleaner into his/her throat during an asthma attack.

In Episode 1, as we listen to his thoughts and feelings for N, we tell him that the grief of parting will not last forever. Medical treatment is not necessarily needed. In Episode 2, while instructing the patient to continue with his current lifestyle, we interview him about his recent situation as well as his developmental and upbringing history, and consider insight-oriented psychotherapy. Medical treatment should be provided according to the patient's request. However, if the patient does not ask for it, there is no need to pursue it too deeply. In Episode

3, we recommend rest and prescribe antidepressants before psychotherapy. If the patient does not wish to be treated, we should inform his/her intelligent sibling and other significant others and ask them to cooperate with the treatment.

These choices should not be made on a case-by-case basis, but rather in accordance with criteria based on medical knowledge that has been accumulated up to that point. In particular, there should be criteria to distinguish episode 3, which should be treated mainly with pharmacotherapy, from other episodes. Therefore, a reevaluation of the concept of endogenous depression is required.

II. Symptoms of endogenous depression

Endogenous depression is a disease, just like severe manic depression. Symptoms arise from physical causes. In this sense, it is comparable to a cough with pneumonia or nausea with a gastric ulcer.

Depression and sadness in endogenous depression appear in the area where the mind and body intersect. The internal heaviness and restlessness rooted deep in the chest, i.e., internal restlessness and agitation, may be more closely described as anguish than depression or sadness. This is what Schneider, K. 29)31) calls vital depression and vital sadness (vitale Traurigkeit).

Vital symptoms also appear on the motor side. Thinking and acting are suppressed. They are jammed up and not moving forward, slowing down because of this, with an inability to make decisions. Even the smallest action requires a great deal of effort. This is an experience that is inextricably linked to the inner restlessness and agitation of vital sadness. These are also called vital inhibition (vitale Hemmung) 16).

These are in accordance with endogenous laws, i.e., the inherent rhythms of the organism. The manifestation of this is diurnal variation. They are accompanied by other physical symptoms, such as sleep disturbance and loss of appetite. In most cases, the patient is most unwell when awakened in the early morning, and the condition improves during the day, evening, and night. They have no problem falling asleep.

Vital depression, vital sadness, and vital inhibition in endogenous depression do not respond to external comfort, encouragement, or threats 12). They are unresponsive. This is also called non-reactivity. All sensitivities disappear. Moods and emotions are unmoved. They are not shaken, not in the depths of grief, and unable to grieve. This is what Schulte, W. 32) calls inability to mourn

(Nichttraurigseinkönnen).

Unresponsiveness and non-reactivity are also manifested in the course of the disease. Once endogenous depression begins, it persists. The course is endogenous and autonomous. Pleasant events do not bring about recovery. The duration of the disease can range from a few months to more than a year. Eventually, however, the patient is cured. Once on the road to recovery, it is not reversed by a sad event 31). However, recurrence and repetition are common throughout the course of the disease.

In endogenous depression, the suffering, incapacity, and social disadvantage caused by the disease make the patient want to escape from this life. They want to die. This mentality is also common in those with other chronic diseases such as cancer. There is room for sympathy in this suicidal ideation.

However, this is not all. Endogenous depression includes primary suicidal ideation that can only be described as arising directly from a physical cause. Just as a person with pneumonia coughs, or a person with a stomach ulcer becomes nauseous, a person with endogenous depression becomes suicidal 35). There is no reason for it. We must know this fact. We must not forget it.

Vital depression, vital sadness, vital inhibition, inability to mourn, and primary suicidal ideation do not respond to the imagination, empathy, or sympathy of those who come into contact with them. They are different in quality from the depression experienced in daily life. Hamilton, M., states: "The patient's mood is not the same as the normal experience. A self-aware and intelligent patient would realize this, but the difference can only be described metaphorically" 6). Schulte states: "When a patient wants the healthy people around him or her to understand him or her in some way, the only way he or she can do so is to use the familiar metaphor of 'sadness'" 32).

This may give the impression that endogenous depression is serious. It is true that the patient's experience is serious. However, outward appearances do not necessarily give the impression of severity. If attention is paid to suicidality, most patients have mild depression that can be treated on an outpatient basis.

Many patients present to the outpatient clinic with psychiatric and physical symptoms related to the stresses of daily life. This miscellaneous assemblage used to be called neurasthenia, hysteria, and neurosis. Today, it is called MDD. The ability to extract endogenous depression buried in it was one of the raison d'être of psychiatrists 27). There was certainly

such a time.

III. Endogenous depressive symptoms from the viewpoint of diagnostic criteria for MDD

The diagnostic criteria for MDD 4)21) are based on the template of depressive mood that everyone experiences in daily life. This is an approach from the opposite direction to that of endogenous depression, which uses severe manic depression as a template.

However, the diagnostic criteria for MDD contain traces of the symptomatology of endogenous depression. This involves the diagnostic criterion A2, "marked decrease in interest or pleasure "21). In DSM-III, it is "loss of interest or pleasure "2).

"Loss of pleasure" represents unresponsiveness and non-reactivity of mood in endogenous depression. Also known as anhedonia. According to Klein, D. F. 14)15), this symptom is the best indicator of the indication for antidepressant medication.

Klein 15) further divided anhedonia into two stages: loss of appetitive pleasure and loss of consummatory pleasure. The loss of appetitive pleasure corresponds to "loss of interest", and the loss of consummatory pleasure corresponds to "loss of pleasure". Appetitive pleasure is the "pleasure of hunting," i.e., the pleasure of pursuing prey or planning enjoyable events. Consummatory pleasure is the "pleasure of feasting" that follows the pleasure of hunting, and is directly related to the satisfaction of biological needs such as eating, drinking, and sexual intercourse.

Appetitive pleasure is the pounding feeling when you search for live information about your favorite musicians to get information about dates and venues quickly, when you access the Play Guide to purchase tickets at the exact time of the release date, when you check the seating chart to imagine how the stage will look, and when you choose the outfit to wear for the day. Consummatory pleasure is to enjoy the live performance to the fullest and discuss one's impressions with friends on the way home.

The loss of appetitive pleasure has low specificity even though it has high sensitivity to endogenous depression. It is present both in depressive reactions and depressive neurosis. The loss of consummatory pleasure has high sensitivity and specificity for endogenous depression and is an important indicator for antidepressant use.

A patient had lost interest in his former favorite musician and was unresponsive to announcements of live concerts, but only when a friend secured tickets and picked him up at home by cab on the day of the concert did he take

the plunge. The venue gradually revived his old enthusiasm, and he responded with a hearty "Arena!" call and during a memorable hit song, he snatched a bath towel with the logo from his friend and threw it up in the air, returning home very satisfied. The next day, however, he returns to his normal state, complaining that he should never have gone to the concert and that he did not enjoy it. This is the loss of appetitive pleasure. The consummatory pleasure is preserved. The diagnosis is depressive neurosis.

On the other hand, even though he has lost interest in the musician, he does not cancel his membership of the fan club, applies for the ticket reservation lottery out of inertia, and does not feel excited even when he wins the lottery. On the day of the concert, he bought all the pamphlets and goods as before, and stood and clapped formally in the standing room, but the musician whom he had admired so much did not shine as brightly as before. Yet, the other audience members are just as enthusiastic, and he feels a sense of alienation. On the train ride home, he just feels empty. The next day at work, he hands out souvenirs to colleagues as he does every time, but when asked what he thinks, he is a little puzzled, and after a delicate pause, he smiles awkwardly and says, "Well... it was fun". This is the loss of consummatory pleasure. The diagnosis is endogenous depression.

Current clinical practice of depression does not distinguish between these two psychopathologies. Both are MDD.

If we narrow diagnostic criterion A2 to "loss of pleasure and sadness", it is almost equivalent to an inability to mourn. We can diagnose endogenous depression. However, the actual diagnostic criteria were expanded from "loss of pleasure and sadness" to "loss of pleasure" to "loss of interest or pleasure" to "marked decrease in interest or pleasure". Furthermore, A2 is an OR condition with A1 "depressed mood. It may or may not be present.

MDD provides no information about underlying physical causes, events, or mental conflicts suppressed in the unconscious realm. This is why DSM-III called it atheoretical and not based on theory 2). Even so, until DSM-IV, there was a 5-axis assessment that took into account the biopsychosocial model 3), but DSM-5 abandoned that as well 4). The development of biological markers is meaningless, since the diagnosis of MDD does not depend on the presence or absence of physical causes*7, and as a result, the treatment plan for MDD is left to the discretion of the treating psychiatrist and wishes of the patient on a case-by-case basis.

IV. Usefulness of the concept of

endogenous depression

The diagnosis of endogenous depression is for treatment*8. First, the diagnosis relates the patient's distress to treatable symptoms and informs the patient of the course and prognosis. Next, rest and recuperation are prescribed, and finally, a plan is devised to deter suicide. This sequence of procedures itself leads to a good outcome. The suffering of hunger may be intolerable if left unattended, but it can be tolerated if we are clearly informed of the policy of promptly providing food and the timing of meals. Patients suffering from endogenous depression must be clearly informed of the prospects for recovery over the next few weeks and months, and of the course of treatment.

As mentioned earlier, the experience of endogenous depression does not consider the imagination, empathy, or sympathy of those who come into contact with it. This psychopathological fact is the key to treatment. Schulte states: "The assertion that the patient's condition is empathetic is intrusive. Instead, the patient would feel better 'understood' and accepted if he or she were silently acknowledged as incomprehensible". The patient is already overwhelmed, bewildered, and at a loss by the heterogeneity of the experience. If this is the case, it is better to understand the heterogeneity of the experience and tell the patient: "I don't understand", so that the patient feels "understood". At first glance, this may seem paradoxical, but from a higher perspective, it is consistent. This "understanding of the incomprehensibility" is the first step in the treatment of endogenous depression.

However, endogenous depression does not recover even if psychotherapy addresses the basis of symptoms or pathogenic mechanism. In the same way, psychotherapy does not reduce or eliminate physical lesions such as cancer. If psychotherapy appears to be effective in treating endogenous depression, it is either because the depression is not endogenous or it has resolved spontaneously 30).

In the 1940s, electroconvulsive therapy was introduced, and in 1957, tricyclic antidepressants were introduced as highly specific physical treatments. Since then, the treatment guideline for the diagnosis of endogenous depression has shifted from the initially stated invalidity of psychotherapy to efficacy of electroconvulsive therapy or tricyclic antidepressants 20), *9.

The role of psychotherapy was also re-evaluated. A psychotherapeutic attitude based on a psychopathological understanding of the disease is essential for the treatment of endogenous depression 22)25)26). This is the same as the necessity of a

psychotherapeutic attitude toward patients facing chronic diseases such as cancer.

Kasahara summarized this in: "Little Psychotherapy for Depression in the Phase of Disease" (1978) 10). Later, it was called: "The Seven MundTherapie of Depression" (1982) 11) or "Seven Principles of Treatment in the Acute Phase" (1996) 13). They are as follows: (1) The physician must confirm that the patient is ill, (2) the patient must be allowed to rest as quickly and as much as possible, (3) the expected time to cure must be clearly stated, (4) the patient must pledge never to commit suicide, at least during treatment, (5) all decisions regarding major life issues must be postponed until the end of treatment, (6) repeatedly point out that the patient's condition is going up or down during treatment, and (7) point out in advance the importance of medication and the accompanying autonomic nervous system symptoms that may occur with medication.

This approach has been widely effective in the clinical treatment of depression in Japan. Okuma's textbook: "Contemporary Clinical Psychiatry," from its second edition in 1983 included these seven articles/seven principles along with the statement: "Do not encourage the patient by saying, 'Pull yourself together and cheer up,' as this will increase the patient's sense of remorse and despair" 19).

In this way, in addition to the therapeutic significance of the diagnosis of endogenous depression itself, physical treatment and psychotherapeutic guidelines specific to the diagnosis were provided. This is the usefulness of the concept of endogenous depression.

Conclusion

The wisdom of the clinical practice of depression in Japan has been with endogenous depression. Kasahara declared: "I think that the problem of 'diagnosis' is unexpectedly important in discussing psychotherapy for depression" 10). Okuma, too, assumed an "accurate diagnosis, for example, differentiation between endogenous depression and neurotic depression," 19). The scope of application of little psychotherapy is the Kasahara-Kimura classification 9) of Type I (personality-responsive depression) and Type II (cyclothymic depression), especially Type I, i.e., the disease phase or acute stage of endogenous depression.

The guidelines for the treatment of modern depression, or MDD, state that: "etiology should be considered, and whether the depressive state of individual patients is largely due to a biological basis or whether it can be viewed as a psychological reaction that can be understood psychologically and

socially" 18). The awareness of the problem was the same in the past as it is in the present. However, it is the MDD literature in English that is referred to there. The psychopathological understanding of endogenous depression and accumulation of treatment experiences in Japan, which are discussed in this paper, are not considered at all.

However, the concept of endogenous depression and its usefulness are worthy of re-evaluation. Therefore, the author presented this essay in the hope that those physicians who are about to become psychiatry specialists will be familiar with the fact. It may not appear in the examination.

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Some of the non-Japanese quotations are taken from translations, but even in those cases, the author himself referred to and re-translated the original. Therefore, the responsibility for all quotations is solely with the author.

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Notes

1 "Utsubyo (DSM-5)/Dai–utsubyo" in "Guidelines for the Treatment of Depression, Second Edition" 18), but "Utsubyo (DSM-5)/Dai–utsubyo–sei–shogai" in DSM-5 Japanese edition published in 2014 4).

2 The origin of MDD can be found in DSM-III 2) published in 1980.

3 The author previously referred to depression in Japanese psychiatric practice before 2000 as "Japanese Depression" 27).

*4 Windows XP is an operating system (OS) of Microsoft Corporation, widely known for its ease of use and prairie wallpaper. It was launched in 2001 and discontinued in 2008, but its support period was extended many times and ended in 2014. Some people still use it today.

5 Syndrome is a combination of "syn" and "drome," so it originally refers only to cross-sectional symptoms. In actual clinical practice, however, the term "syndrome" is used with some flexibility, and may or may not include the course of the disease.

6 This case is a fiction. It is not related to any actual work, person, or organization.

7 For example, the validity of a tumor marker is evaluated by comparison with the cancer lesion itself. Comparing tumor marker values with psychosocial measures in cancer will never approach validity.

8 It is not known what physical causes underlie endogenous depression. Therefore, validity 24) has not been established. However, past knowledge has been accumulated about its usefulness 24) for treatment.

9 Antidepressants are still the first-line treatment for endogenous depression. Tricyclic antidepressants are the most widely used antidepressants for the treatment of endogenous depression. The evidence for new antidepressants, including serotonin reuptake inhibitors, is exclusively focused on MDD.